TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AHMED KHALIFA, MD

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE CO

MFDR Tracking Number
M4-17-2129-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MARCH 15, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $559.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Interpretation of the EMG/NCV is part of the professional component of those codes and should not be counted as a required key component of the E&M…HCPCS Codes A4556 and A4215 were denied as bundled or non-covered procedure based on Medicare guidelines; no separate payment allowed."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2016	CPT Code 99204 New Patient Office Visit	$251.26	$0.00
	CPT Code 95886 (X2) Needle EMG	$275.88	$275.88
	CPT Code 95910 Nerve Conduction Studies	$0.00	$0.00
	HCPCS Code A4556 Electrodes	$16.90	$0.00
	HCPCS Code A4215 Needles	$15.00	$0.00
TOTAL		$559.04	$275.88

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97-Payment is included in the allowance for another service/procedure.
   - X212-This procedure is included in another procedure performed on this date.
   - 234, MSCP-In accordance with the CMS physician fee schedule rule for status code "P", this service is not separately reimbursed when bill with other payable service.
   - 150, B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.
   - 150, X901-Documentation does not support level of service billed.

Issues

1. Does the documentation support billing CPT code 99204?
2. Does the documentation support billing CPT code 95886(X2)?
3. Is the allowance of HCPCS code A4556 included in the allowance of another procedure performed on the disputed date of service?
4. Is the allowance of HCPCS code A4215 included in the allowance of another procedure performed on the disputed date of service?

Findings

1. According to the submitted explanation of benefits, the respondent denied payment for CPT code 99204 based upon reason codes "X212-This procedure is included in another procedure performed on this date," and "97-Payment is included in the allowance for another service/procedure."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   The American Medical Association (AMA) Current Procedural Terminology (CPT) defines code 99204 as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

   The Division finds that the requestor's documentation did not support a comprehensive history or medical decision making of moderate complexity; therefore, the requestor did not support billing CPT code 99204.

   In addition, on the disputed date of service, the requestor billed for CPT code 99204, 95910, 95886 and A4556.

Per 28 Texas Administrative Code §134.203(a)(5), the Division referred to Medicare's coding and billing policies. Per Medicare fee schedule, CPT code 95886 has a global surgery period of "ZZZ" and code 95910 has "XXX.

The National Correct Coding Initiative Policy Manual, effective January 1, 2016, Chapter I, General Correct Coding Policies, section D, states:

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure… Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX' procedure is correct coding.

The Division finds that the requestor did not identify a significant and separate E&M service to support billing CPT code 99204 in conjunction with CPT codes 95886 and 95910. In addition, the requestor did not append modifier 25 to CPT code 99204 per the correct coding guidelines. Therefore, the Division finds that the requestor's documentation did not support billing CPT code 99204. As a result, reimbursement is not recommended.

2. The respondent denied reimbursement for CPT code 95886 based upon reason code "150, X901-Documentation does not support level of service billed."

   CPT code 95886 is defined as "Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)."

   A review of the submitted report supports billed service; therefore, reimbursement is recommended.

   To determine reimbursement for CPT code 95886 the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2), which states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2016 DWC conversion factor for this service is 56.82.

The Medicare Conversion Factor is 35.8043.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78230, which is located in San Antonio, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Rest of Texas".

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable	Carrier Paid	Due
95886	$87.31	$138.55 X 2 = $277.10 or less, the requestor is seeking $275.88	$0.00	$275.88

3. According to the submitted explanation of benefits, the respondent denied payment for HCPCS code A4215 based upon "150, B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed."

   HCPCS code A4215 is defined as "Needle, sterile, any size, each."

   HCPCS code A4215 is not covered by Medicare in any payment system; therefore, reimbursement is not recommended.

4. According to the explanation of benefits, the respondent denied reimbursement for HCPCS code A4556 based upon reason code "234, MSCP-In accordance with the CMS physician fee schedule rule for status code "P", this service is not separately reimbursed when bill with other payable service".

   HCPCS Code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."

   Per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service to support billing HCPCS code A4556. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $275.88.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $275.88 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		03/28/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.